GETTING STARTED IN MEDICAL LOGISTICS

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I. INTRODUCTION:

A. PURPOSE:

Welcome to Medical Logistics; one of the most exciting, challenging and rewarding jobs in the Medical Service Corps! The information provided is not sacred. It is intended as an overview of areas the new logistics officer can dive into quickly to get a feeling for the status of his/her account. Each account is different; the mission, command, strengths of personnel, and philosophy of the Commander/Administrator will all dictate which "squeaky wheel" gets the grease.

B. WHY/WHAT:

When you first begin working in medical logistics you may say to yourself, "I'm not sure what language these people are speaking in this movie, but I wish it came with subtitles." Learning the technical jargon of any job is a slow process and medical logistics is no different. With a little pointing in the right direction the learning process can be accelerated. Peter Drucker, the management theorist once said, "We often spend a considerable amount of time doing things right when our time might have been better spent doing the right things." Hopefully this guide will help you do both. You may also contact the 384th Training Squadron (DSN 736-6974) about attending a “Return to HSA” session on Medical Logistics.

C. ROLE OF THE MEDICAL LOGISTICS OFFICER:

Medical logistics officers are truly unique individuals. They report to the Administrator or Support Squadron Commander, work for the MTF Commander, but are appointed by the Installation Commander; answer to their bosses, but are pecuniary liable for the items under their control; manage storage areas, none of which belongs to the facility until it leaves the warehouse door; are responsible for overseeing the integrity of the AFWCF, for which they are monitored by their Major Command and Air Force Medical Logistics Office (AFMLO), but are charged in AFMAN 23-110, Vol 5 to ensure that the using activities receive outstanding materiel and services support. They are also responsible for Facility Management, Biomedical Equipment Maintenance and sometimes additional areas. It certainly is a job of contradictions, but also the most rewarding job in the medical facility. There is no other job that holds as many tangible rewards for one's efforts. Everything in medical logistics can be seen, touched, or tracked statistically. The result of your labor can be seen every time you walk down the hallway. You can notice the quality of the building maintenance as you walk throughout the facility. The things you buy provide direct support to patients by providing the health care staff the tools and supplies they need. Everything in medical logistics has an audit trail. It is a perfect example of the production model many of

you were exposed to in college. There are inputs, transformations, outputs, and feedback loops every step along the logistics way. This makes the career field very technically oriented. However, at the same time you must be customer oriented. Every transaction is driven by a previous input and results in a subsequent output. Medical logistics is a dynamic and innovative area with initiatives such as Forward Logistics, Prime Vendor, credit card purchases, limited contracting warrants for local purchase items, shared procurement for large dollar equipment, and centrally negotiated blanket purchase agreements for a large portion of the routine local purchase needs. Most of you reading this pamphlet come from one of three backgrounds: you are brand new to the Air Force and have been assigned to Medical Logistics as your first MSC assignment; you are in, or a graduate of, one of the logistics internships at a large facility; or you are an MSC who has had an assignment in some other area such as Tri-Care, Personnel and Administration, Resource Management or Medical Systems. All of you have been to the Health Services Administration (HSA) course at Sheppard AFB and have had a brief overview of the medical logistics world. For some, logistics will become your home, for others it will be a weigh station on your journey to some other destination. Regardless of what vehicle brought you here, welcome. As you read this pamphlet, make notes on which items prove to be helpful, and which could be changed or deleted. This pamphlet is for you. Your inputs and comments are important. Send recommendations by letter or facsimile to: HQ AFMSA/SGSLP, Bldg 170, 2504 Gillingham Dr, Ste 39O Brooks AFB TX 78235 or fax DSN 240-2984.

D. MAIN TOPICS COVERED IN THIS PAMPHLET:

Assuming accountability.

Initial management techniques.

Marketing your account.

Medical Logistics System (MEDLOG).

Key managerial computer products.

Medical Equipment Maintenance and Clinical Engineering program.

Facility Management.

Medical Equipment Management Office (MEMO).

Vehicle Control

Training Opportunity

Career opportunities within medical logistics.

Keep in mind, this pamphlet does not presume to supersede the information in AFMAN 23-110 Vol 5, AFI 41-201, 209 or AFCSM 41-230, Vol I. They will become your bibles, this is but a missal.

II. DISCUSSION - AREAS OF CONCERN:

A. ASSUMING ACCOUNTABILITY:

You begin to get a feel for the uniqueness of the medical logistics field when you first see how many letters of appointment it takes to transfer the account to you. The most important document of transfer is the special order or letter of appointment signed by the installation commander appointing you the medical accountable supply officer. You derive your authority from this document. You also sign a certificate of transfer showing at what point you

assumed responsibility for the account. The format is shown in AFMAN 23-110, Vol 5, Chapter 1, paragraph 1.6. Some of you will also be appointed the Medical Equipment Management Officer (MEMO). The position is appointed by the MTF Commander, and is an officer (41Ax), noncommissioned officer (minimum 7-level TSgt), or civilian (minimum GS-5) with Primary Air Force Specialty Code (PAFSC) 4A1x1 or 4A2x1. The certificate of transfer for both medical logistics and MEMO must be assigned a "T" document number and filed in the documents file. Besides these documents, there are a large number of letters of appointment which will bear your name, such as approval authority for local purchase, authorization to sign receiving reports, ordering official, etc. See Appendix II (Letters of Authorization). If not already in existence, establish a Letter of Appointment notebook to maintain and update these letters as needed.

Before you sign the letter of transfer; STOP! LOOK!, and EVALUATE! Know what you are signing for. The account you sign for is yours. Be sure you know what you are inheriting, and resolve any problems before you sign. Here are some areas to look at during this evaluation:

Code R and Q items. These are the controlled drugs and precious metals kept in the vault. There is no margin for error here. There will be vault inventory cards, AF Form 105F-2 cards, showing the balances on all Code R, and at most accounts, Code Q items. Conduct a complete physical inventory with your vault custodian. Count every item! Be sure any discrepancies are corrected before you sign for the account. Ask to see a copy of the last biennial inventory of controlled substances. It should be dated 1 May of the appropriate year. NOTE: Although AF Forms 105F-2 are not required for Code Q items, they are used at most accounts.

Review the Inventory Accuracy Analysis Report for the latest annual inventory. Ensure a complete supply inventory has been completed within the last 12 months. Stock classes that were below a 95 percent accuracy rate should have been re-inventoried within six months of the initial inventory. Be sure all inventory adjustment documents are available and have been approved (signed) by the installation commander or his designee (usually the MTF Commander).

Conduct a spot inventory to estimate current inventory accuracy. Take 15 or 20 items in different stock classes as a random sample. If the accuracy rate is off by more than 15%, you might consider a complete inventory. Keep in mind complete inventories take a great deal of time, disrupt your operation, and impact your support to the MTF.

Conduct a spot inventory of your War Readiness Materiel (WRM) Projects. Review the WRM Stock Status Report and evaluate your wartime mission. Visit the WRM storage facility and inventory 5 items from the WRM Quality Assurance Listing to ensure on-hand balance, quality assurance balances, and quality assurance information have been properly maintained. Choose those items which have reasonable accessibility as projects are often palletized or stacked for storage space or rapid deployment.

Review the most recent MAJCOM Staff Assistance Visit (SAV) and Health Services Inspection (HSI) reports. Ensure discrepancies noted there have been either corrected or a plan has been implemented to address these matters. We recommend all these become open items in your self-inspection program.

If you are also being appointed the MEMO, review the equipment custodian accounts. Ensure each account has been inventoried within the last 12 months and a property custodian has been appointed by the MTF Commander or designee. Also be sure the Custody/Receipt Locator lists are signed by the current custodian. Be sure the person signing these locator lists is also on the property custodian letter. When you are satisfied with the conditions under which you are assuming the account, go ahead and sign the transfer documents. If your predecessor has departed prior to your arrival, and there are significant problems with the account, be sure to talk to your Administrator or Support Squadron Commander, and document these with Memos For Record. The account is now all yours! Don't be surprised if you feel like a first class passenger sailing out of Southhampton Harbor on your way to New York aboard the TITANIC; the view is great, but you have an uneasy feeling in the pit of your stomach about the future. Hopefully, your predecessor maintained a "continuity folder." Better yet, if your predecessor is still present when you arrive, he/she can be a great source of information when performing your initial self-inspection.

Some questions you might ask are:

What is the mission of the base and how does medical logistics fit in with this plan?

Who are your customers and what sources of supply do you use?

Does your account take maximum advantage of Prime Vendor programs to reduce cycle time and inventory requirements?

What are the strengths of the account? Of the individuals assigned, who is ready for more responsibility?

Are there any underlying problems which are just below the surface?

When was the last time the self-inspection checklist had been run, and what were the results?

Of your current staff, who is "hot" for orders?

What type of relationship exists with base agencies such as Contracting, Defense Accounting Office (DAO), Civil Engineers, Communications, Base Supply and Transportation and who are the key players and/or contacts in these organizations?

What is the status of the equipment program? How many approved unfunded requirements exist?

What is the equipment review process? Is there an ERAA board or another designated authority to review equipment requests and make recommendations to the MTF Commander for approval/ disapproval?

Which MTF accounts have strong custodians and which need help? What is their perception of logistics?

Are there any special programs in existence; i.e. imprest funds, credit cards, limited contracting warrants?

What has been the most nagging problem which could not get resolved during their tenure?

What kind of program exists for handling hazardous materials and hazardous waste?

What facility projects are upcoming? What is their status now?

How many work orders are over 90 days old in the Medical Equipment Maintenance section? What's the cause?

What metrics have been established and how are they used to continuously improve processes in Medical Logistics?

B. INITIAL MANAGEMENT TECHNIQUES:

The first few months will be exciting, frustrating, hectic, boring, rewarding, and most of all confusing. This is to be expected.

1. There are four steps you can take to mitigate this feeling:

Step 1. Ask questions about everything you sign.

What is the document for?

By what authority?

What happens as a result of signing?

What is the meaning of the information (on the form)?

What factors should be considered before signing?

Step 2. Ask questions about everything your NCOIC signs.

Step 3. Ask questions about everything your staff does.

a. What are you doing?

b. Why are you doing it?

c. What value does it add?

d. What are the results in customer service?

e. What governing directive explains this procedure?

Step 4. Ask Again. During these first few months you cannot ask enough questions. Often times the answer won't make complete sense; don't worry, it will come. Make your people explain things in plain English, don't let them snow you with jargon. Once you understand what the transaction accomplishes, learning the acronym is easy. Your asking questions has a dual benefit; first of all you will learn more about how your account operates, but just as important, by explaining how or why they do something, your staff improves. By providing you the explanation, your staff sees you as interested in their job area, it also makes them take a critical look at how they operate. Too often people accomplish tasks in a certain manner because that is how they have always done it. Sometimes your "new" eyes can see areas for improvement or modification in which more experienced staff have become complacent. Use your management expertise and common sense to suggest improvements. Don't ever feel dumb about asking questions. The worst thing that could happen is that you might learn something. Also, remember everything brought to you for signature is done so because you are the accountable officer. It is not only your right, but your obligation to know what you are signing.

2. Get to know your staff, they are your life support system. Get to know who reports to whom and how the different functions interface. Spend time in the work sections. Visit your biomedical maintenance support section and observe how they fix medical equipment. Take a seat in facility management and answer the phone for a bit to see how facility management deals with their customers. Go into the warehouse and run receipts and put up stock. Help pull issues for some of the larger accounts. Work the Document Register doing some of the quality control procedures. File some documents to get a feel for the sheer bulk of that chore. Do the research on a Local Purchase request. Make calls on Blanket Purchase Agreements (BPA). Process an End-of-Day (EOD) on MEDLOG. Try your hand at everything; you will have a whole new respect for your staff.

3. **J**ust as important, get to know your facility. Spend as much time as possible doing what Tom Peters, the management expert, calls MBWA (Management by Walking Around). It is amazing how much you learn about your logistics support to the facility by walking the hallways, standing in elevators, sitting in waiting rooms, and talking and listening to patients, technicians, providers, and other staff. Look at the blueprints for all of your buildings. Go everywhere in the building you can. If you can get on the roof, do so; if the building has a crawl space, go down there as well. Be sure to visit the power plant, know what color the boiler is and when it was installed. The more you know about the facility itself, the easier it will be to visualize the problems brought to you by your facility manager and to explain them to your boss. Be sure to visit all the outlying buildings that you are responsible for. In short, do everything you can to acquaint yourself with your surroundings.

4. **S**oon after you arrive, make appointments to visit the Base Supply and Contracting Officers, Accounting and Finance Commercial Services representative, and the Civil Engineering Commander. Be sure you prepare for your visit by reviewing with your staff what "the sleeping dogs laying out in the weeds" are. A review of the facility master plan is a must before visiting CE. All of these agencies provide critical support to your facility. Get to know your counterparts on a personal level. It is much easier to deal with someone you know than to ask for something from a stranger. By visiting your counterpart's work areas you also get a better idea of what some of their limitations are, either physically or regulatory. It also shows you are interested in their agency. A word of caution -- don't dump problems on your counterpart during your introductory meeting. Use this time to develop a positive relationship that will facilitate future problem solving efforts. Be sure to invite them to visit you at the clinic/hospital as well. Arrange a specific time and set up a tour. When a new piece of equipment comes in which took close coordination with Contracting, invite your buyer and contracting officer over to see it in operation. Too often these items are just purchase orders to them, let them see that there is a patient being provided better health care because of their efforts. Don't forget that the contracting officer is probably a beneficiary as well. Let them see they have a personal stake in the quality of care your facility can provide. Let them know when they do a good job. Nothing costs so little, but goes so far, as a letter of appreciation to an individual or agency which has provided you outstanding support on a particular project, or during a specific time period.

5. **M**eet your customers. Set up a meeting with the OICs/NCOICs of your major accounts. If you are assigned to a clinic, your biggest customers are Pharmacy, Clinical Laboratory, Dental Services, Radiology and the Primary/Acute Care Clinic. If you are in a hospital, you can add Emergency Room, the wards, Central Sterile Supply, and Surgery. Set up a time when you can visit them. This will become an ongoing activity as customer visits are critical to your monitoring of facility support. Take them on a tour of medical logistics. Many of these people have never been in the warehouse. To them, medical logistics is a black hole where you throw in a requisition and if you wait long enough the item appears. How it got there or what your people did to get it is one of those glorious mysteries that defy explanation. Follow-up with informal, drop-in meetings. Be visible!

6. **R**eview the Medical-Dental Division Budget. The budget process is becoming more centralized, but for now, its submission is controlled by your MAJCOM. Some commands require you to fill out all four parts, others do not. The budget input by your predecessor is the basis for what you have to operate on for the current fiscal year. The budget is submitted in four parts:

Medical work load and net sales format; and

operating budget statement; and

medical war reserve materiel format; and

operating plan format.

Check the latest monthly status of the operating plan format and compare the actual against the planned position. You can use PCN SH118-SF0 or the worksheet in Vol 5, Chapter 5. If the actual aggregate monthly inventory is plus/minus the planned aggregate by more than five percent, research the cause and determine corrective action. Sometimes the cause for this variance is beyond your control. The gain/loss of a single provider in a small facility can throw off the budget. For every month that the actual aggregate inventory is plus/minus more than five percent of the planned aggregate for the entire command, a variance report must be submitted by your MAJCOM. Your MAJCOM may require individual base variance reports as well. In the report, identify what caused the variance and what steps are being taken to correct this situation. Be sure to provide an estimated get well date. If the situation is not going to be resolved for several months, it may be necessary to submit a revised operating program to your MAJCOM. Guidance can be found in AFMAN 23-110, Vol 5, Chap 5. Preparing the budget is not an activity to be undertaken by the faint of heart. It is complicated, which is why some MAJCOMs prepare their bases' budgets centrally. Get your NCOIC to help you prepare this revised budget, or if not centrally prepared, your next year's operating budget submittal; it's a great exercise in educated guess analysis. Personnel in the AFMLO Air Force Working Capital Fund Branch are the focal point for managing this report. Call them for advice and information.

7. **E**ssential Information (or how the new logistics officer can dazzle them with their footwork). There are certain facts, information, and statistics which you will need to have at your finger tips. These are the facts that commanders and administrators readily need and understand. You earn a lot more "brownie points" at a staff meeting when asked about the status of a certain large piece of equipment if you can say, "It was ordered on 8 June, and the Contracting Officer awarded the contract on 12 July. The vendor has until 14 October to deliver the item and we have confirmed they have received the purchase order," rather than saying, "All I can tell you is that we put it on order." You certainly are not expected to memorize the entire Due In/Due Out Suspense List, but you will quickly surmise which items are of high interest to the command section. Here is a list of some key facts to have close at hand.

Average Weekly and Monthly Sales. This information can be obtained from the Project Fund Management Report (PFMR) which is produced after every MEDLOG EOD. The monthly Using Activity Issue/Turn-In Summary will break this down to sales of supplies, expense equipment, and investment equipment.

Base Medical Inventory Management Report. This report provides a great deal of useful information. It has various data accumulated by

requirement code including: average pipeline time, excess figures (how much is in excess and how much has been reported), fill rate percentage (a favorite statistic of the Executive Staff). Further information about this report can be found in AFCSM 41-230, Vol I Chap 24.

War Reserve Materiel (WRM). WRM is what we really are all about. While the bulk of our effort is spent supporting our peacetime mission, we exist to support war. WRM is a critical part of your job. In an Health Services Inspection (HSI), your facility's overall rating cannot be higher than one level above the readiness grade. In short, keep your WRM program in good shape. As the Director of Medical Logistics (DML) or Medical Logistics Flight Chief, you will normally be the WRM project officer. You should know what programs are assigned to your facility. This information is in the WRM Medical Readiness List or WRM Stock Status work list. See AFCSM 41-230, Vol I, Chap 24 for more details on the reports. WRM materiel availability is usually reported monthly under Status of Resources and Training System (SORTS). This report receives HQ USAF/SG visibility, so be extra careful in compiling these figures. See AFI 10-201 for details on the SORTS report. Your role is to provide these percentages to the Medical Readiness Officer or Resource Management monthly. They will prepare the SORTS report. Review the narrative remarks or Limiting Factor (LIMFAC) summaries being submitted on the SORTS report to ensure they accurately reflect the status of shortages. Be prepared to brief or provide information to brief the MTF Commander or even the Wing Commander on materiel availability, WRM funds status and status of critical items.

Status of Equipment Procurement Programs. Because equipment is of high visibility, and often high cost, it is an item which often appears on the agenda of facility staff meetings. You should have a feel for expense equipment items (those under $100,000 each) that are on order, and definitely know the status of investment equipment requests (those over $100,000 each). Due-in/Due-out files within MEDLOG and the Using Activity Back Order Report will contain this information. Most of the time, there will also be a number of items which have been approved but are unfunded. Have a feel for what is on that list as well. This information is obtained from the MEMO section. While no one would expect you to memorize the entire list, it will soon be apparent which items are "hot" and which are not. The more detailed information you can have about these items, the more enjoyable the staff meeting will be. Providing a prioritized list of unfunded requirements keeps the MTF staff informed, prompts MTF leadership to take funding action and shows you are proactive and aware of your customers' needs.

Status of Biomedical Equipment work orders. Is the biomedical equipment support section repairing equipment, performing preventive maintenance inspections, and calibrating medical equipment in a timely manner? The customers know the answers to this question so you should have a good handle on the reason for the status of the work orders. You should look at trends of work orders and the overall manning within the section to be ready to answer any questions relating to equipment maintenance.

Status of Facility Management Projects. Be prepared to answer questions relating to status of civil engineering projects and other requests that have been turned in to facility management. Ensure you have an up-to-date copy of the Facility Master Plan, are informed of project status, know about critical work requests that affect patient care, and are aware of those special issues that the MTF Executive Committee has an interest.

Executive Management Briefing Book. If not already in existence, develop one. In it, select those items of high interest to the executive management of your facility. Information you ought to have at your fingertips is: sales, status of WRM programs, excess, and status of equipment. Some areas to consider for inclusion would be receipts vs sales, fill rate, inventory stratification, and charts of trends. It should also include manning status, project information, work order status, etc. Have key members of the executive staff initial off on it. This shows any IG inspector there is executive management involvement in your area. It also goes a long way towards fulfilling the old Holiday Inn advertisement slogan, "the best surprise is no surprise at all."

Requests for Local Purchase. At most facilities, the Medical Logistics Flight Chief is given approval authority for routine local purchases, except for new drugs. Whether or not a local purchase committee is in operation, you must review all new local purchase requests. For Local Purchase requests of large dollar values, coordinate with Resource Management for budget impact. You may be given a dollar limit for your approval authority. Ensure review actions required by AFMAN 23-110, Vol 5, Chap 16 are conducted. Attachment 2 in Chap 16 gives a good example of a Local Purchase Request format.

C. MARKETING MEDICAL LOGISTICS:

You may have the best account in the entire Air Force on paper, but if your customers don't feel they are getting the support they need, you haven't provided outstanding service. In medical logistics, perception can be just as, if not more, important as reality. Therefore, you must manage that perception. If your customers perceive they are getting "outstanding" support, they will make your job very enjoyable. If they don't, no amount of explaining will make it better. To your customers, perception is reality. Here are a few steps you can take to market your services.

1. Visit Using Activities. Visit using activities as often as you can (AFMAN 23-110, Vol 5, Chap 1, para 1.3.7). Some visits should be informal and just a brief "How Goes It," while others should be more formalized. There are some who believe that if the mid-shift charge nurse does not know who you are, you are not properly marketing your account. In either case, be sure to take the time to assess the level of service being provided. Check to see that your Forward Logistics program is meeting the activity's needs, the right items are being supplied, they know how to add and delete items from their Shopping Guide, equipment is being serviced as required, they receive prompt and courteous service, and things which are very clear to you are just as clear to them. Make notes of your visits and follow up on any items you find that need additional work. The HSIs are looking very closely at the area of customer support. An informal register with the date, section, person contacted, and follow up items goes a long way to documenting this support. Be

sure you follow up on those items that need it. Don't make promises that you cannot keep, and avoid "hallway" requisitions. This is where someone in a using section, often times a provider, requests an item from you, and you indicate that you will take care of the matter. Instead, assure this individual that you will contact their supply custodian so that a request can be put into the system, and that they should contact this same individual in a day or so to be sure it was requested. Most providers are not interested in the intricacies of the supply system, they only know that when they go to treat a patient, they want the supplies or equipment necessary to be there. How or where it came from is of little interest to them.

2. ***K****eep the Nurse Executive, Medical Operations Squadron Commander and Superintendent well informed.* Educate them on your logistics operation. They should be a routine stop on your "how goes it" rounds. They are a great source of information concerning upcoming changes and potential trouble. Keep them informed so they can help you.

3. ***A****s mentioned before, through the use of an Executive Management book, keep your bosses well informed of status of projects, trends, statistics, and even anticipated trouble areas.* Commanders and Administrators don't like unpleasant surprises.

4. ***P****ublish a Logistics Information Letter.* This letter should be informal, informative, and not technical in orientation. It is a marketing tool, and should be written accordingly. Some examples of subjects you may want to include are:

a. Changes in ordering dates or procedures

b. Local excess items available (Blue Light specials)

c. Ordering deadlines for seasonal items (e.g., calendars, snow shovels, summer camp physical day items, dental health week material).

d. Ordering deadlines for equipment requests to meet the next Equipment Review and Authorization Activity (ERAA) board

e. Advertise new services

f. Introduce new staff

g. Supply training

h. Recognize outstanding custodians

5. ***C****onduct Structured Training Sessions.* All newly appointed Property Custodians and Supply Representatives should receive initial training. After the initial training session, take your new customers on a tour of logistics. Be sure they can put a face with a name when they call. Customer training/education is important, so, if you don't have a formal training program for your customers, develop one. Once new customers have been trained, they'll require refresher sessions. These sessions should address new procedures, requirements, and reinforce past training for experienced custodians. Discussion at these sessions should be at the technical level with specific procedures outlined. Refresher training should take place at least quarterly, in either a formal group or an individual session.

6. ***A****ppoint a Customer Liaison/Service Representative.* A single point of contact in medical logistics simplifies the using activity's interface with your activity. This representative is not intended to be a gate to keep people out,

but a conduit to channel the requests to the person or section that can be most helpful. One area this person may be particularly helpful is in channeling QA messages (i.e. product recalls, suspensions, materiel complaints, etc.) to the customer and within Medical Logistics. This does not necessarily have to be your most senior person, but someone who projects a positive image for your account, and someone with enough experience that they can direct questions to the proper person/section. In no way should you allow this to take the place of your customer visits as outlined in section (1) of this paragraph. As we move further and further "forward", the need for a separate customer liaison function should decrease.

7. ***P****rovide Briefings at Staff Meetings*. Go forth and spread the word about medical logistics and what services you provide. Market Logistics at every forum you can; Professional Staff, Nursing Services, Enlisted and Officers Commander's Call, Clinic/Hospital Executive Committee, in short, anywhere there is an audience. This can be a very enlightening experience for both presenter and audience. Topics should be general, and cover policy changes, equipment status, and other specifics of the medical logistics system which would be of interest to your audience.

8. ***B****rief Cost Center Managers*. Many times in smaller facilities, the cost center manager is also the supply custodian. If possible, work with your Resource Manager to consolidate this list so that "two birds can be killed with this one stone." Be an active participant in these meetings. The Using Activity Issue/Turn-In Summary should provide the Resource Manager with the information he/she needs for their statistics.

9. ***P****rovide a Staff Orientation.* Be sure all medical officers and senior NCOs are given a briefing on what medical logistics can do for them. Make it convenient for your customer. Consider briefing them at their leisure in their office. If there is no current program, cover this in a staff-wide orientation. Once established, it is easiest to comply with this requirement during in-processing. Make sure Medical Logistics is on the inprocessing checklist, and be sure to document your briefings! What a great time to hand your customer his or her name stamp, doctor's coat, and logistics information pamphlet. Orienting all newcomers can add even greater organizational benefit.

10. ***D****evelop a Medical Logistics Pamphlet or Handbook*. A custodian guide is available from HQ AFMSA/SGSL on disk that you can modify to meet local needs. If you already have a guide, read it and ensure it is sufficiently detailed so the custodians can rely on it as a handbook. Keep the information specific but avoid jargon. It should be a cookbook approach on obtaining and utilizing the services you provide to the MTF.

11. ***D****evelop a Customer Satisfaction Questionnaire*. This questionnaire should cover those areas under your control; materiel, equipment, facilities, biomedical equipment repair, linen, vehicles, etc. The questionnaire should be anonymous so that respondents can be completely honest. Don't get defensive about the responses. What you receive back is what the users perceive your level of support to be, not what your statistics show. Negative responses form the basis for briefing topics, newsletter articles, visit topics, and changes in policy. They also form the basis of action, such as new procedures, new attitudes, etc. You should distribute this questionnaire to the OICs, NCOICs, and custodians. You might try using a

Likert scale such as: 1= Outstanding, 2= Excellent, 3= Satisfactory, 4= Marginal, 5= Unsatisfactory, 6= Not Applicable. This way you can do some statistical manipulations on the results as well. Try including such open ended questions as, "What is the most frustrating aspect of dealing with Medical Logistics?" Surveys don't necessarily have to be an annual event. You could publish one every six months and measure if the improvements you have made are being recognized by the users, or target specific users, clinics, or staff positions. This can be a very useful tool in your efforts to improve support to the customers.

*12. **I**nstill a Proactive Attitude in Your Staff*. There will be times that someone will sit you down and explain that you may be going a little overboard in your support to the facility. Don't worry! Too many times, accounts and staff members in those accounts have done things the same way for many years, not because they were the best way, only the most familiar. Remember that nothing is sacred. Before trying a new idea, discuss it with some of the old hands. It may not be new at all. If it was tried before and didn't work, try to find out why it failed. If you still think it is a good idea, try to avoid the pitfalls it fell into before. You are only constrained by your imagination, regulation, and public law. To quote Tom Peters again, "Too often the approach is Ready, Aim, Fire; when what we need more of is Ready, Fire, Aim." His point is that too often we analyze decisions to death. It's better to try new things, if they don't work, readjust your sights and try again. Don't violate regulations or public law, but don't be afraid to teach old dogs new tricks. A word of caution, keep in close contact with your bosses and MAJCOM before you get too far out on that limb.

D. THE MEDICAL LOGISTICS SYSTEM (MEDLOG):

While the soul of medical logistics is serving the customer, the life blood is computer generated reports. You will soon find yourself up to your elbows in computer paper. It will seem to you that everything in your new job is somehow boiled down to another report. When you get oriented to your surroundings, you will soon discover the culprit in this paper avalanche is the MEDLOG computer system. Getting a basic understanding of what is generated out of the MEDLOG system will help you manage your account. A complete listing of the reports available through MEDLOG can be found in Attachment 5 at the end of AFCSM 41-230, Vol I. A few essentials on the system follow.

1. **D**aily Processing Cycle. MEDLOG is an on-line system which allows daily input of transactions and provides a variety of products during the on-line session. Every 24 hour period, you will run an End-of-Day (EOD). During this time the computer summarizes all transactions, prepares necessary issue lists, creates a document register, creates requisitions for different sources of supply, generates follow-ups which will go to Contracting and the Defense Personnel Support Center (DPSC), interfaces with Accounting and Finance so that bills can be paid, and creates many other reports every day. In addition, it can produce a whole list of special request items such as Historical Maintenance Reports (HMR), Special Purpose Stock Status reports, or download files for "ad hoc" reports of your choice. In short, the MEDLOG system is a vital cog in your operation. You may be able to operate without it for a short period of time, but only under unusual situations. When MEDLOG

“goes down”, find out why and ensure corrective action is being taken. Your level of support to the MTF will be dramatically effected if the computer is down too long. Don't let anyone convince you that it is O.K. to "trick" the computer and delay runs for several days. The system was designed to process its “batch” EOD every 24 hours; don't take a short cut to disaster. Too many operations depend on the products and output from MEDLOG. Don't let Finance convince you that if you run every day, they can't keep up. Don't let finance drive you. Without a run, vendors cannot be paid. Furthermore, you can't obtain the following: updated status on requisitions, contracting follow-ups, listings of requisitions, customer pull lists, current document register, and receipts for items which have come into the warehouse. In short, if someone asks you if it's okay not to run the EOD, remember the immortal words of Nancy Reagan, and "Just Say No!"

2. **O**utput of the MEDLOG System: The MEDLOG system has many levels of output product response; on-line, daily, monthly, and as required. Again, Attachment 5 in AFCSM 41-230, Vol I details all of the reports, but the following is a quick summary. On-line outputs are ones in which immediate attention is required by the personnel in your section. This would be such things as emergency issues, destructions, stock number and unit of issue changes, and purchase orders. Most products are generated during the EOD processing and will require action the next duty day. These are generated at the end of the day so as not to consume too much on-line time. Other products are generated during the End of Month (EOM) processing which are more general management tools and reports. In all, there are over 100 reports produced by the MEDLOG system. While you certainly won't be expected to work these listings on a daily basis, you will be expected to understand what the report's "bottom line" is telling you. The more you know about the reports, the more you can delve into these murky logistics waters which are inhabited by what seems like a million three letter transaction "piranha."

E. COMPUTER OUTPUT PRODUCTS:

As mentioned before, your MEDLOG system produces mountains of reports. While most of them have very specific information useful to a specific section, there are some that provide you information on the general health of your account. Knowing what these contain, and the "symptoms" that indicate problems are part of being a good account manager. Detailed information on these products is available in AFCSM 41-230, Vol I.

1. **M**onthly Stock Status Report. This monthly report lists irregularities with descriptive messages for items reviewed. The computer is programmed to flag deviations to the "norm" in such areas as pipeline time, on-hand plus due-in balances versus level and due-out balances, issue history, etc. Entries on this report require review and may require corrective action. Remember that the report only detects deviations from the "norm." There may be very good and legitimate reasons for actions you have taken which triggered this "abnormality." Keep in mind that computers only detect deviations, they can't reason, judge, or have a "feel" for ordering peculiarities of your account. Work this report with your NCOIC to develop an understanding of the report's content and use. After a few months, you will only need to review the NCOIC's actions annotated on the report.

2. **M**edical Materiel Requirements List. This listing is prepared during the EOD and EOM processing. Planned changes to MEDLOG include on-line processing. It consists of five parts:

a. Medical Routine,
b. Non-medical Routine,
c. Medical Priority,
d. Nonmedical Priority, and
e. WRM Requirements (prepared only when requested).

It's computer generated and lists new and continuing requirements. Periodically, you should review the annotated Requirements List, in particular, all requisitions with a priority designator of 01-10. These requisitions are being suggested for order on a priority basis. It's important to keep the number of priority requests to a minimum. Just because an item is on the "priority" requirements list doesn't necessarily mean it has to be ordered as a priority. Use your judgment. When very high priority requests are received at DPSC, all routine requests are put on hold, minimum order quantity is ignored, the shortest expiration dated item is sent, and premium shipping is used. In short, everything about priority requisitions costs more. If it's a Local Purchase item, the Base Contracting Office has certain order parameters that they must meet to fulfill ordering deadlines. Again, all routine items get pushed farther back on the pile, and a downward spiral begins to develop. The more priority requisitions, the more the routines get delayed. The more they become delayed, the more the need for priority requisitions, and so it goes. You also develop the "Boy Who Cried Wolf" reputation. If everything is a priority, then all priorities become routine. Things to look for on this report include:

a. Orders for large quantities or dollar amounts should be researched to determine if they are correct (use transaction ITH in MEDLOG). These may be the result of ordering errors by using activities, unit of issue problems, or processing errors by logistics staff. Potential requisition quantities near or greater than your operating level should be investigated.

b. Scan the report for equipment (expendability code 2 and 3) items. With the exception of WRM requisitions, they should have an associated due-out. This is because you do not order equipment for stock, you just pass the order to Contracting, and then through to Medical Equipment Maintenance Office (MEMO) once it is received. If a due-out does not exist, refer the problem to your MEMO for immediate resolution. If you find a requirement for equipment on your Requirements List, it may indicate that an existing due-in has been canceled. Before reordering, investigate what happened, or you may find yourself with a duplicate quantity.

c. Review all items being ordered through Base Contracting, DBPAs, or from DPSC. Some of the items may be available through your Prime Vendor (PV). Any item found to be available from PV should be converted immediately unless readily available through DPSC at the lowest delivered cost.

3. **U**sing Activity Issue/Turn-In List. This product is prepared during the EOD and a Using Activity Issue/Turn-In Summary is prepared during the EOM. You should review these lists in order to gain a feel for what customers are buying. Particular attention is required for nonmedical customers to ensure they are purchasing items that have been approved by the MTF Commander or authorized representative

and no using activity outside the medical chain is ordering nonmedical supplies. You will have many non-medical customers who order items through your account. Certain stock classes are restricted as medical, although the item may have more general usage. Such things as cotton swabs and isopropyl alcohol are used in almost every computer room and electronics shop to clean equipment. Be sure you have a letter on file from each of these activities on who is authorized to order and receive items, and a list of items they anticipate ordering. Although the monthly Activity Issue/Turn-in Summary is primarily a customer's report, there is information on this report that can be important to you as a manager.

a. Review and possibly chart individual activity summaries for several months. You may find trends which indicate poor ordering practices. If this is evident, it can be made a topic at customer training sessions and staff meetings. As a general rule, activities should not order quantities larger than the using activity level on the shopping guide. If you see this happening consistently, it is time to step in and find out why.

b. The last page of the report for each customer shows totals for reimbursable and nonreimbursable supplies and equipment, and provides the percentage of local purchase versus standard medical supplies. Check to see if there are nonreimbursable issues for medical supplies or equipment. If so, verify as correct because a footnote may be required on the Medical Materiel Management Report (MMMR). Remember, when we issue items refund code "N," the Medical-Dental Division of the Air Force Working Capital Fund (AFWCF) is not reimbursed.

4. **M**edical Materiel Management Report (MMMR). This report is produced monthly, but can be requested from Finance at any time. It shows the financial status of the account from beginning of the fiscal year through the current month. It shows the financial effects of all transactions processed by medical logistics and the Finance. Major commands receive a copy of this report, and AFMLO receives the contents via AUTODIN or DDN. This is one of the most complex reports you receive. It is also one of the most important. Work with your NCOIC to gain a working knowledge of the uses and contents of this report. A detailed explanation can be found in AFCSM 41-230, Vol I, Chapter 24. AFMLO's Air Force Working Capital Fund Branch personnel can help explain this report and help you analyze it. The report itself actually is produced by Finance and forwarded to you; it does not print as part of your EOM processing. Some management hints for working this report follow.

a. Avoid just reviewing the current month's report. The report is much better suited for trend analysis than "picture in time" uses. You may want to chart and compare certain line items such as excess to see if the rate is increasing, decreasing, or remaining constant. Has your inventory increased over the last few months? Why? Are you building inventory, or just over ordering? This report is a very useful instrument in providing a financial picture of the health of your account.

b. Check that the due-ins and due-outs for expense and investment equipment balance. Remember you never want to have equipment due in without an accompanying due out. Equipment is rarely, if ever, brought in for stock. If the due-ins do not match the due-outs, find out why and make necessary corrections.

c. Take a look at any significant increase or decrease in price changes. An erroneous increase will cause an over-expenditure of O&M dollars, whereas an erroneous decrease will cause the AFWCF to lose money. A solid quality control plan, whereby the Catalog Change Actions List is reviewed daily, will significantly reduce these problems.

d. If excess has been on the increase, find out why. Did you just recently transfer an old WRM project into excess? Are you over-ordering? Are you transferring items into excess too quickly, and not waiting for the economic retention stocks to be issued? The monthly Stock Status Report is the tool to identify potential excess. Ensure the report is being worked at the start of every month.

e. An increasing balance in suspended items may indicate that disposition action is not being taken. This can easily be corrected by having your warehouse NCOIC review the latest consolidated list in the Air Force Medical Logistics Letter (AFMLL), plus all recent updates, or the ABBIE module of the Air Force Medical Logistics Office Home Page http://www.medcom.amedd.army.mil/afmlo/

5. **W**RM Medical Readiness List. This is produced automatically each month except January, February, July, and August. It may also be produced “on-line” for required project codes whenever up-to-date information or percentages are needed. The list is your primary data source to determine the WRM materiel availability for the monthly SORTS report. All shortages and overages are listed on the report, unless a WRM project has all items equal to 100 percent, in which case only a project summary is provided. You should review all overage conditions and make sure actions have been taken to correct the condition. Overages may occur because of an improperly applied prime substitute relationship, or unit pack adjusted receipt; in either case, action should be taken to correct the overage. Shortages should also be reviewed to identify new shortages that may have an impact on your readiness percentage. WRM assets are unique in that they are funded out of special appropriations and should only be ordered upon receipt of WRM funds. Questions will arise any time you submit readiness percentages lower than the previous month's figures. Possible causes include Table of Allowance changes, mission changes, inventory adjustments, or dated item expiration. Be sure you know the specifics so your MTF Commander is prepared to explain the change to the Wing Commander. Your main focus should be to use this report to monitor WRM programs and ensure your personnel take corrective actions.

6. **N**onrotatable Dated Item List. This is prepared monthly and quarterly. The monthly list shows all items that have expired or are due to expire the following month. It is sort of your "critically ill" list of supplies. This list gives you a good indication of destructions you have because of non-rotation. The quarterly list (as of March, June, September, and December) is used to determine the necessary actions to be taken on nonrotatable dated item stocks. You should review this list, after annotation by the NCOIC, or other individual assigned, to ensure items are either used or reported excess to avoid destruction of dated items. This is more a "serious ill" list, that will become "critical" if you don't step in and take some positive action.

7. **W**RM Medical Stock Status Worklist. This is prepared semiannually in January and July. It can also be requested anytime, except

during end of month February and August processing. The list may also be requested anytime as an as required product. This worklist is used for SORTS reporting and to support budgeting and financial planning. During the February and August EOMs, the "worklist" becomes a report. The MTF Commander must review and sign the August report so be prepared to brief the details. AFMLO/FOCW uses the semi-annual worldwide reports to produce the Preposition War/Other War Reserve Report for the Defense Logistics Agency to figure stockage objectives and to do industrial planning. It is very important that your WRM records are correct prior to the February/August runs so that correct information can be used for planning purposes.

8. **D**ocument Register: One output product that you will only rarely review, is also one of the most important quality control tools available to your staff, the Document Register. Remember that production model with the input, transformation, output, and feedback? Well, the Document Register is the log of all this activity. Almost all of the transactions that went into the transaction file had source documents. These source documents, after the transaction was input, were given to the quality control section to hold for quality control. After daily processing, the quality control monitor is provided the Document Register. The listing shows each transaction that processed the previous business day. Your clerk then compares the source document with the document register to ensure the transaction processed the way it was intended. Once all source documents have been quality controlled, they can be filed. A complete quality control program requires that the clerk also check and research the document register for entries that require source documents, but do not have them. This situation may indicate an erroneous transaction or a misplaced source document requiring immediate resolution.

9. **R**equisition Trouble List. One of the most useful reports produced by the MEDLOG system on a daily basis is the Requisition Trouble List. For more detailed information than is below, see AFCSM 41-230, Vol I, Chap 8. The Trouble List is broken down into four parts:

a. Part I is the most important portion of the Trouble List. It identifies items whose on-hand balance is below the prescribed safety level, and a requirement is not generated because there are sufficient quantities due-in to cover the requirement. In other words, you have backordered 24 widgets because you are completely out. The computer checks its records and finds you have already ordered 36 two days ago. In Part I of the Trouble List this situation is brought to your attention. Sometimes there will be legitimate reasons to go ahead with a new order, such as the older order was on Routine, and this order is going in Priority. If so, it will have to be generated manually since no requirement will appear on the Requirements List.

b. Part II identifies due-ins that require follow-up action when shipping status or updated status has not been recorded. In other words these requisitions have fallen into "never never land" and the computer is warning you that your intervention is required to find out the status on this overdue item.

c. Part III shows requisitions that have shipping status posted, but are overdue. The problem could be that the box is really lost in shipment, or it could be a matter of it is sitting in your warehouse, but has not been received yet. Another place to check for this item is at the

Transportation Management Office (TMO) or at Base Supply. Often times our items get mixed in with theirs and it's just a matter of picking it up. TMO will also provide assistance in tracking shipments which do not make it to their destination.

d. Part IV shows all due-in items that have a purchase order/call number loaded. This list is very valuable to your receiving personnel in the warehouse, as it provides a cross reference from purchase order/call number to due-in document number.

10. **S**ummary. These are just some of the reports and listings that the MEDLOG system generates. Remember these reports are to be used as the basis for managerial decisions. Don't be driven by the numbers on the reports, you and your staff are the drivers. Take some time to track a listing to the individual in your office who works it, how that listing ties into another, and so forth. Take a proactive stance on determining where your account is headed. The numbers will soon catch up with you.

F. CLINICAL ENGINEERING PROGRAM:

As the Medical Logistics Flight Chief, your "kingdom" extends beyond medical supply. One of the most complex areas under your direction is Medical Equipment Maintenance. The primary missions of Medical Equipment Maintenance are repair, preventive maintenance, calibration, and safety testing of medical equipment. In recent years, the world of medical maintenance has expanded dramatically. More and more time and effort is spent in the areas of operator training, equipment acquisition support, accreditation requirements, service contracts, quality assurance/risk management issues, and expanding involvement in facility management and equipment management (MEMO). At some facilities, you may find Medical Equipment Maintenance combined with the Medical Equipment Management Office (MEMO) and/or Facility Management. The integration of these responsibilities is detailed in AFI 41-201. The combination of Medical Equipment Maintenance with MEMO is a logical marriage of activities because it provides a central focus for all equipment related matters. If these functions have not been combined, consider it for the future. Be aware that it won't work everywhere, but it has proven effective at several facilities, especially the smaller ones where synergistic combinations are necessary due to lack of staff. The important thing to insure is that all three of these functions work together on overlapping areas of responsibility and expertise in order to provide for the best planning and support for the medical facility.

1. **T**he Biomedical Equipment Technicians (BMETs) are trained extensively in the technical aspects of their duties. The entry level BMET course is 42 weeks long with a 30% washout rate; sort of makes your HSA class pale by comparison. Several advanced courses are also available and many courses on specific equipment systems are available from manufacturers. In addition, BMETs are continually provided current technical and management information through the Clinical Engineering Section which is included in each *AFMLL*, and *HEALTH DEVICES*, a civilian publication provided to each Medical Equipment Maintenance activity through a centralized AFMLO contract. These publications should be put on your required reading list as well. While

you may not understand much of the technical language or electronic schematics, the basic information will keep you abreast of happenings in this critical field and medical equipment technology in general.

2. **Y**our biomedical equipment support section is only one part of the chain of maintenance and engineering resources available within the Air Force Medical Service. Medical Equipment Repair Centers (MERC) have been established on a regional basis to provide intermediate level maintenance support. The MERC visits your facility, at least annually, to provide scheduled calibration and technical services beyond the capability of the local BMETs and to review local maintenance management procedures. The MERC is also available for backup maintenance support and assistance, on both technical and management issues. Find out who your supporting MERC is. Find out when they were last at your facility. Read their last trip report. Ensure all their recommendations were implemented or find out why not. In addition, the Clinical Engineering Branch at AFMLO (DSN 343-4124) is also available for assistance on matters related to equipment, facilities management, and technology management.

3. **Y**our BMET shop will have a great deal of impact in the medical equipment portion of your Quality Assurance/Risk Management (QA/RM) programs. The condition of the highly sophisticated and technical equipment directly affects the quality of care available to the patients. For example, a miscalibrated instrument can cause misdiagnosis, and defective equipment can result in serious patient injury or death. Certain pieces of equipment are so critical that they will affect the entire mission when they aren't functional. Be sure your BMETs are proactive in their approach to QA/RM and safety issues and are an integral part of the MTF Safety Committee. Ensure that preventive maintenance and calibrations are performed as scheduled, that Medical Device Recalls and hazard reports are reviewed and corrective action taken, and that a positive attitude exists toward identification and prevention of accidents.

4. **A** breakdown in a critical system can also be very expensive to your facility. If patients cannot obtain certain required services, such as x-rays, they will have to be referred to civilian facilities. For active duty personnel, the full amount of their bill will come out of the medical treatment facility's O&M budget. For dependents and retirees, the government will have to pick up a large portion of the CHAMPUS claim. As soon as possible, have the senior BMET identify to you the facility's critical medical equipment systems and their relative potential problems so you will know what needs close attention. In addition, you should establish a protocol to keep informed of the major systems that are experiencing significant problems to assure timely repair or, if necessary, replacement.

5. **A**mong your biomedical equipment support responsibilities will be to monthly review all work orders outstanding for sixty days and beyond. Take a look at the cause of the delay, is it awaiting parts? sent to contractor for maintenance? etc.? Be sure needed parts are on order and that proper follow up action has been taken by medical materiel. Make sure not ordering a part is not the reason a piece of equipment is down. Recurring requirements for hard-to-acquire critical parts indicate a need to increase bench stock levels. The Defense Personnel Support Center (DPSC) has established several Decentralized Blanket Purchase Agreements for repair parts. You

should ensure that your local purchase section makes maximum use of these ordering instruments.

6. Review with your BMET Superintendent/NCOIC all equipment items under contract. Maybe there is equipment under contract which could be maintained internally. Perhaps sending a BMET to a class may eliminate the contract or reduce the contract cost. Always evaluate all repair and replacement alternatives as equipment purchase and repair are major parts of the hospital budget.

7. The Biomedical Equipment Maintenance Management Report (PCN SI008-Y10) is produced by the MEDLOG system at the end of each month. It provides a summary of management indicators that you may find helpful in managing the biomedical equipment support function. Detailed information on the content of the report can be found in section 21.31 of AFCSM 41-230, Vol I.

8. Your customer satisfaction rating may be influenced to a great extent by the ability of your maintenance staff to keep equipment functional, and their attitude toward customer service. As you walk through the facility (remember MBWA {Management By Walking Around}) take a good look at the equipment the providers are using. Is it new?, old?, appear well maintained? state of the art? or obsolete? Are the equipment operators satisfied with the level of maintenance support? On the other side of the coin, you should use your BMETs as a valuable source of feedback. The BMETs are frequently in most sections of the facility. They deal directly with end users and see and hear things which you won't. Talk to them. Ask them questions. Express concerns you may have. Rely on the feedback they provide you, especially on conditions of equipment, operator maintenance, reliability of the equipment, etc. They are your technical experts in equipment, maintenance, and electrical safety.

G. MEDICAL FACILITIES MANAGEMENT:

One of the most diverse areas under your purview is facilities management. This activity is responsible for the operation, maintenance, repair, alteration, safety, and security of medical buildings and their associated utility systems and grounds. The overall objective of facilities management is to provide the most suitable and productive environment for normal medical operations and planned contingencies.

The following paragraphs offer some helpful hints and guidance for new Medical Logistics Flight Chiefs who have facilities management as one of their areas of responsibility. While nothing can substitute for actual hands-on experience, the recommendations included here should help you get off to a good start.

1. Recognize the unique challenges facing facilities management. In addition to being characterized as "diverse," facilities management is also considered by many to be the most challenging area within medical logistics. While this is partially due to the technical nature of the functional area, a number of other factors contribute to this perception. These include the rapidly changing nature of the facilities management career field and the increased regulatory controls, a historical lack of staffing, a lack of automation, a shortage of personnel with functional area expertise, high turnover of personnel, and, perhaps most importantly, the facilities manager's lack of direct supervision over the resources needed to accomplish the mission. For example, housekeeping is performed under a contract with an outside company, and maintenance of the physical plant is performed by Base Civil Engineering (BCE).

Fortunately, improvements are occurring on some of these fronts. To address the lack of automation, for example, a medical facilities management automated information system is being developed for use by all DoD MTFs. In addition, the increased recruitment of clinical engineering officers and increased use of 4A2X1 *Biomedical Equipment Maintenance* personnel has increased our corporate knowledge in the area of facilities management. Still, change has not occurred rapidly enough to meet the demands placed on the facilities manager on a day-to-day basis. The best advise to you is to recognize the unique challenges facing your facilities manager, do your best to develop (and encourage your people to develop) innovative solutions to solve your MTF's specific problems, and be willing to offer resources, support and guidance when necessary.

2. Become familiar with the many governing regulations, directives, codes, and standards. Medical facilities management is governed by the requirements of many directives, regulations, codes, standards, and guidelines. The principal direction for facilities management in Air Force MTFs is found in AFI 41-201, *Managing Clinical Engineering Programs*. Medical Logistics Flight Chiefs should be thoroughly familiar with the requirements set forth in AFI 41-201, Chapter 4, *Establishing a Facility Management Program.*

In addition to AFI 41-201, a number of other Air Force and DoD directives apply to facilities management. While you will not need to memorize these, you should at least take the time to confirm their presence in the MTF and skim over them so you'll have a basic idea of what they cover. Some of the most important are AFI 31-209, *The Installation and Resources Protection Program;* AFI 32-1021, *Programming Civil Engineer Resources - Appropriated Fund Resources;* AFI 32-1031, *Operations Management;* AFI 32-1061, *Utilities Service;* AFI 32-2001, *Fire Protection Program;* AFI 41-203, *Electrical Safety in Medical Treatment Facilities;* AFI 64-108, *Base Level Service Contracts;* AFI 91-202, *The US Air Force Mishap Prevention Program;* AFOSH 127-8, *Medical Facilities;* AFI 32-9005, *Establishing, Accounting, and Reporting Real Property;* AFI 32-1023, *Design and Construction Standards and Execution of Facility Construction Projects;* and Military Handbook 1191, *Design and Construction of DoD Medical and Dental Treatment Facilities.*

Furthermore, a number of regulations, codes and standards established and maintained by civilian agencies apply to all health care facilities including Air Force MTFs. Some of the most important are NFPA 99, *Standard for Health Care Facilities*, NFPA 101, *Life Safety Code*, and NFPA 70, *National Electric* Code, all published by the National Fire Protection Association (NFPA); the *Accreditation Manual for Hospitals* and *Accreditation Manual for Ambulatory Health Care*, both published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and various standards and regulations published by the Occupational Safety and Health Administration (OSHA) and Environmental Protection Agency (EPA).

Once again, you do not need to read each of these publications in detail, but you should be aware of the role each has in the establishment of an effective medical facilities management program. A list of other essential publications can be found of page 93 of AFI 41-201.

3. Become thoroughly familiar with the facilities manager's range of responsibilities. The facilities manager has what has been described as an endless list of responsibilities. AFI 41-201, Chapter 4, outlines these responsibilities; however, for convenience, they are shown here grouped into five major programs. Where applicable, the key sub-programs are listed also:

a. Facilities Operations and Maintenance (O&M) Program

1) Facility Maintenance and Repair
2) Facility Project Management
3) Communications System Management
4) Housekeeping
5) Waste Management
General Refuse
Medical Waste
6) Signage
7) Grounds Maintenance

b. Safety Program (Mishap prevention)

c. Life Safety Program (Fire Protection and Prevention)

d. Security and Resources Protection Program

e. Facility Planning Program.
1) Facility Utilization
2) Master Planning
3) Energy Conservation Planning
4) Disaster Planning

To be an effective manager, you will need to develop a thorough understanding of these responsibilities. Schedule a one-on-one meeting with the facilities manager and ask him to go over each program area and what his goals and problems areas are for each one. You will play an important role in helping the facilities manager establish priorities for each of his areas of responsibility.

In addition to the above responsibilities, many facilities managers are also responsible for things which are not specifically listed in AFI 41-201. Some examples are linen management, laundry contract management, and hazardous materials and waste management. Be careful about adding extra duties to the facilities management function without also providing additional manpower support.

A primary responsibility of your facilities manager which was not listed above is attending meetings. While all health care managers have to attend lots of meetings, chances are your facilities manager will be involved in far more than most people. Furthermore, many of these meetings are base meetings. As a result, the facilities manager will probably become as well-known around the base as the MTF commander and administrator!

Base-level boards and committees of which the facilities manager is usually the MTF representative or a key participant include the Base Facilities/Space Utilization Board, Base Communications/Information Systems Requirements Board, Base Energy Steering Group or Energy Efficiency Council, Base Safety Committee, and Base Security and Resources Protection Committee. MTF-level boards and committees which the facilities manager is a member include the Facilities Utilization Board, Safety Committee, Infection Control Committee, and Equipment Review and Authorization Activity. So you will be aware of the many outside commitments your facilities manager has, you should ask him to provide you with a list of all the meetings he is required to attend. You should also ensure he has adequate time to prepare for meetings, especially base meetings where he serves as the MTF representative.

4. Recognize the complexity of facilities management and the importance of adequate staffing. Despite facilities management's long list of responsibilities, many in the MTF still think the facilities manager does little more than keep the grass cut, issue keys, place service calls to BCE, and remove dirty diapers from the parking lot. In other words they fail to recognize the complexity of the facilities management function. The Air Force Medical Service went a long way towards recognizing the complexity of the facilities management function when, several years ago, the AFSC for the facilities manager at many MTFs was changed from 4A0X1, *Health Services Management*, to 4A2X1, *Biomedical Equipment Maintenance*. This was more than a subtle change. It was an acknowledgment that the complexity of managing medical buildings is more in line with this more technically-oriented career field. Because facilities management is now part of the

Biomedical Equipment Maintenance career field, you should ensure your 4A2X1s are receiving training and experience in this functional area. Attendance at course number J3AZR4A271-012, *Medical Facilities Management*, is strongly encouraged for new facilities managers. You should make every effort to support the attendance of your facilities manager (and his/her staff) at this course.

As stated at the beginning, the facilities management function has historically suffered from a lack of staffing. As the facilities management program increased in both size and complexity over the past 10 years, staffing may not have kept pace. The Medical Logistics Flight Chief has the authority to shift resources at the local level. While Air Force Manpower Standard (AFMS) 5530, *Medical Logistics*, specifies the number of personnel who should be assigned to each functional area within medical logistics, you may move personnel around within logistics in order to ensure mission needs are met.

5. **Help your facilities manager develop the communication skills necessary to be successful in the position.** Because the facilities manager will spend so much time interacting and coordinating with base support agencies and other MTF personnel, excellent communication skills are essential. You should provide feedback to your facilities manager as necessary to ensure he or she continuously works at improving both oral and written communication abilities. The most successful facilities managers are highly professional in all their dealings with others. Despite any frustration they may have with the system, they are capable of keeping their emotions under control and being courteous and diplomatic at all times. Although sometimes you may feel it is the only solution, you do not want an individual who is inflexible, belligerent, and antagonistic serving as the MTF's key representative to base agencies. If you have such an individual, you will most certainly receive poorer support than would be received if the individual conducted himself in a more professional manner. If you have the opportunity to hire a new facilities manager, you should keep this in mind as well. While technical abilities are important, they are useless if the person cannot effectively communicate and interact with a wide range of people.

6. **Don't forget to discuss facilities issues when you meet with key MTF department chairmen.** One of the recommendations in the medical materiel section of this handbook was to meet one-on-one with key department chairmen to discuss logistics issues. When you conduct this meeting, be sure to not to forget about facilities issues. You will want to discuss concerns about adequacy of the department's space, quality of facility maintenance support, quality of support received from the facilities management office, known or projected requirements for facility modifications, etc. Knowing the concerns of these key personnel will help you prioritize your efforts.

7. **Cultivate a positive working relationship with base support agencies.** In addition to developing good relationships with your colleagues in the MTF, you should begin to establish a rapport with base agencies such as Base Civil Engineering, Base Communications, Base Contracting, Base Safety, the Fire Department, and Security Police. One of the best ways to accomplish this is to visit each of these base agencies with your facilities manager. When you visit, take along a list of the MTF's priorities for that area. Explain to each base agency that the facilities manager is responsible for all facilities issues and will be their main point of contact; however, as the Medical Logistics Flight Chief, your job is to understand the processes and help where possible. Taking time early on to develop an excellent working relationship with your counterpart at each base support agency will pay dividends in the long run.

8. **Make an extra effort to establish a strong working relationship with BCE.** BCE will undoubtedly be the base agency with whom

the MTF interacts the most. You should put extra emphasis on developing and maintaining a positive working relationship with BCE. For example, you and the facilities manager should conduct monthly meetings with your counterpart at BCE to ensure your priorities are known. If you have a large backlog of BCE work orders, you should conduct more frequent meetings. All meetings should be documented so you will have a history of overdue work orders and efforts you took to expedite them. If BCE is unable to expedite projects, work with your facility manager and BCE toward securing alternative methods, including the Simplified Acquisition of Base Engineering Resources (SABER) and Tool Box. SABER is a base requirements contract maintained through BCE where projects may be contracted to local community contractors. Tool Box is a joint Army/Air Force initiative through BCE in which projects are contracted through the U.S. Army Corps of Engineers to contractors.

9. Recognize the importance of a facilities program which balances appearance and infrastructure needs. Because medical facilities are the Air Force Medical Service's largest single capital investment, their safe and effective management is critical to the medical mission. The difference between a bright, clean, well-maintained facility and one that is suffering from neglect is instantly apparent. A dirty, poorly-maintained facility negatively affects the morale of the staff who must work in this environment. Furthermore, patients tend to associate the appearance of the facility with the quality of medical care received. If the facility looks bad then there is a greater likelihood that patients will believe they received poor medical care. A neglected facility may also create safety hazards that adversely affect the delivery of medical care.

While it is true that the environment of care plays a paramount role in a patient's recovery, this environment is not just "skin deep." The infrastructure of the facility is just as important, if not more important, than appearance. If your building's appearance is first-rate but the infrastructure is failing and unreliable, then it can be related to "putting lipstick on a corpse"...it may look pretty, but does it work? You should work with your facilities manager to ensure that the master plan for the MTF contains infrastructure, appearance, life safety, safety, and functional space improvement projects. This will ensure a balanced facilities improvement program.

10. Make planning a priority. A balanced facilities program as described above doesn't just happen by itself. It takes meticulous planning, something we may all feel too busy to do. However, it is absolutely critical that you set aside time to plan and encourage (or even demand) that the facilities manager do the same.

The most important plan the facilities manager must develop is the Facility Master Plan. You should help your facilities manager develop a complete Facility Master Plan as required AFI 41-201, Chapter 4. This plan is extremely important; it is the key to ensuring the MTF maintains a balanced facilities project program.

The facility master plan is a long-range planning tool that the MTF's executive committee uses to prioritize facility projects necessary for the operation, maintenance, and future development of the MTF. While the facilities manager is responsible for the plan, he or she cannot develop the plan independently. Preparation of the master plan will require coordinated efforts between the commander, group staff, departments involved in future projects, base civil engineers, base communications, the resources management office and your MAJCOM.

The master plan must take into account all known facility projects required and/or desired by the MTF for the next five years. Infrastructure projects can be developed and initially prioritized by the facilities manager

based on the age, life expectancy, and current performance of building systems. Projects to correct life safety, safety, or energy efficiency problems can be handled the same way. The master plan must also take into account the types and levels of patient care the MTF will be provide in the future. Only after these strategic decisions have been made by the executive committee can specific facility projects be developed. Once the master plan has been put together, the executive committee will have final approval authority. By taking the time to develop a facility master plan, you and your facilities manager will learn a tremendous amount about your buildings and their needs and, at the same time, put your MTF in an excellent position to receive project funding as it becomes available in the future.

The plan is also valuable for completing other facility related requirements. For example, the facilities manager may be involved with the resource manager in completing your MTFs portion of the MAJCOM Mission Support Plan. It is extremely important that the facility master plan is kept current in order to provide timely and accurate data for facility related decisions.

11. Recognize the critical role facilities management has in the accreditation process. In recent years, accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has become a high priority in the Air Force Medical Service. Those MTFs who are already accredited put considerable effort into maintaining their accreditation. Those MTFs who have never been surveyed by the JCAHO almost always have accreditation as an organization-wide goal.

Any facilities manager who has ever been through a JCAHO survey can attest to the critical role facilities management has in the accreditation process. More often than not, accreditation decisions depend on how well facilities management does; but, too often, we wait until six months before a JCAHO survey to take action; at which point it is often too late. You need to realize that preparation for a JCAHO survey is a continuous process. The major programs* the JCAHO evaluates under the *Environment of Care* standards cannot be put together in a few weeks or even months. (If they are, you will certainly not have peace of mind about them.) You will need to make it clear to your facilities manager that you expect him/her to devote time to developing these programs. If you are at an MTF which has only one position authorized in facilities management, you will need to seriously consider assigning additional manpower. It is virtually impossible for one person to manage the day-to-day operation of the facility and still
have enough time left over for long term planning and JCAHO program development, documentation and process improvement.

Historically, the majority of Type I recommendations (write-ups) have occurred in the *Environment of Care* area. If you want to avoid write-ups in this area, you will need to make ongoing preparation a high priority.

* There are seven major programs evaluated under the *Environment of Care Standards.* These programs and the most common OPR are:

Major Programs	**Usual OPR**	**Usual OCR**
1) Safety	Facilities Management	Biomed Equip Maint
2) Security	Facilities Management	

3) Hazardous Materials/Wastes	Medical Materiel **	Facilities Management Bioenvironmental Engineering Military Public Health
4) Emergency/Disaster Prep	Medical Readiness	Facilities Management
5) Life Safety	Facilities Management	
6) Medical Equipment	Biomed Equip Maint	
7) Utility Systems	Facilities Management	

** *There is considerable variation in how primary and corollary responsibility for this program is distributed at the MTFs*

12. Recognize the critical role facilities management has in the equipment acquisition process. As the Medical Logistics Flight Chief, you are ultimately responsible for the acquisition and installation of all new equipment, including real property installed equipment. While the medical equipment management office handles most of the issues related to equipment procurement, facilities management also has an important role in the equipment review process. The facilities manager is the person best qualified to assess the capacity and capability of the physical plant to support requested equipment items. For this reason, he or she should be a member of the Equipment Review Authorization Activity (ERAA) board. The facilities manager must also sign off on a form entitled, *Format of Supporting Statements for Equipment Acquisition*, (Chapter 18, Attachment 6, AFMAM 23-110, Volume 5) for all requests for new equipment items. If additional electrical connections, drains, medical gas connections, sinks, etc., are required to support the installation of new equipment, the facilities manager is the one who will need to submit the necessary work orders to BCE. You should ensure the facilities manager submits AF Forms 332s to BCE as soon as the MTF Commander approves and funds (or will fund in the near future) the purchase of an equipment item requiring BCE support. Don't allow your facility to make the mistake of determining facility modifications are needed after the equipment arrives.

13. Seek out feedback from customers. One of your responsibilities will be to judge whether medical facilities management is effectively supporting the delivery of health care at the MTF. Surveying the staff is one way to gauge the effectiveness of this support. You should make facilities management a part of your normal medical logistics customer survey in order to save time and simplify the process for your MTF customers. You should also encourage staff members to consult you before problems get out of hand.

14. Get to know each of your facilities by taking an in-depth tour with the facilities manager and others as appropriate. It is extremely important that you get to know your facility inside and out, upside and down. As soon as possible after your arrival, you should tour all buildings with the facilities manager and take meticulous notes. As you take your initial tour some specific questions you might keep in mind are:

a. What types of systems are used to heat and cool each facility? What is the age and condition of each? What back-up systems exist?

b. What is the potable water source for each facility? What is the condition of the water distribution system within each facility?

c. What is the condition of the facility's waste water system? Where is the waste water treated? Is there an on-base settling pond?

d. How is hot water generated? Is it a closed-loop or open-loop system? Is there an accurate temperature monitoring system?

e. How is steam generated? What is the condition of the generation system? What is the condition of the steam distribution system? Is the steam treated? Does it meet all applicable standards?

f. What is the source of day-to-day electrical power? Is the MTF supplied commercial power via a dual-feed system? What back-up systems for commercial power exist? In what condition and how reliable are the back-up systems?

g. Is there a need for conditioned power? Which medical and computer systems in the MTF utilize conditioned power? Do the systems adequately protect equipment from power interruptions caused by inclement weather or testing of the emergency generator system?

h. What types of medical/surgical/dental gas and vacuum systems are in place? What is the condition of each system? What is the back-up for each system?

i. Does the MTF have a central oxygen distribution system? Is the source a fixed bulk liquid oxygen tank, portable/refillable liquid oxygen cylinders, or compressed oxygen gas cylinders?

j. Where are the main shut-off valves for the various medical gas (medical air, oxygen, nitrous oxide) and vacuum systems? Who maintains these systems - base civil engineering or a civilian contractor? Do the systems meet current NFPA 99 Standards?

k. What types of fire detection, alarm, and suppression systems are in operation in each facility? What is the condition and reliability of each? Are fire drills being held as required, and is there documentation to prove it?

l. What type of phone switch capability does each MTF have. How many telephone lines come into the facility? How many more numbers can be added before the system reaches maximum capacity? How long does it take to have a phone moved?

m. What types of security alarms are in operation in each facility? What is the condition and reliability of each? Does each system have a remote enunciator at the security police desk?

n. How much regulated medical waste is generated by the MTF? Where is it stored prior to disposal? If final disposal is by on-site incineration, does the incinerator meet all applicable federal, state, and local regulations. Where is the permit maintained? If final disposal is by commercial contract, is the contractor in compliance with all applicable regulations for the transport and disposal of medical waste? What is the cost per pound for disposal? When is the contract up for renewal.

o. How are housekeeping services provided? Who is the contractor? When is the contract due for renewal. Who is the contract QAE (quality assurance evaluator)? Has he/she had proper training?

p. Are grounds maintenance and pest control provided by Base Civil Engineering, a base contract, or an MTF contract?

q. How is maintenance/repair service provided for the following: Elevators? Kitchen equipment? Security alarms? Nurse call system? Beeper system? Patient TVs? Fume hoods? If service is provided by contract, who is the contractor, what are the terms of the contract, and when is each contract up for renewal?

r. Does the facilities manager have blue prints (or access to them) for all MTF buildings and utility systems? Are they current?

s. Does each facility have utility meters for water, natural gas, electricity, etc. If not, how are medical buildings billed for utility usage?

t. In addition to the information on utility systems obtained above, what is the age, installation date, life expectancy, projected replacement date, and back-up for each major piece of real property installed equipment (RPIE), i.e., boilers, chillers, cooling towers, air handlers, emergency generators.

Summary. In conclusion, facilities management is a very diverse and exciting area that will offer you continuous challenges. Take this opportunity to learn as much about the operation as you can. Time spent in this endeavor will not be time wasted. The knowledge gained at this level will make you a better manager, leader, and decision-maker in each subsequent MSC position you hold. In this era of severe spending reductions, few MTFs will be replaced. For this reason, it will be more important than ever that we properly operate, maintain, and repair the facilities that we do have. In the future, the most successful administrators and commanders will be those that understand the complexities of facilities management and use this understanding to make sound decisions that support the delivery of quality health care.

H. MEMO:

The Medical Equipment Management Office (MEMO) is one area that can provide a tremendous sense of accomplishment or can become your biggest source of headaches. Perhaps no other functional area of medical logistics elicits the attention of the medical staff more than the MEMO. MEMO is responsible for the overall management of the whole equipment program for the MTF. Their responsibilities include: purchasing new equipment, accounting for all equipment on MEMO records, disposing of unneeded equipment, coordinating with the BMETs on equipment repairs, and ensuring new equipment is installed in a timely manner.

The medical staff wants and needs the best equipment to provide patient care. Get them that shiny new piece of equipment with the latest buttons, buzzers, and bells and you're a great logistics officer. Get that equipment quickly and you are an even better logistics officer. However, if those providers request an equipment item and are still waiting two years later, you may earn a less than favorable reputation. In the interim, you'll answer a lot of questions and get an earful of complaints. It's up to you to take a proactive approach in the MEMO. Learn as much as you can about the equipment program. Below is an overview of some of the key responsibilities MEMO has, and a synopsis of some of the processes used in equipment management.

1. Equipment acquisition is a cradle to grave process of getting the equipment necessary to accomplish the medical mission. Identifying the need for new equipment can start with any member of the MTF staff. Additionally, MAJCOMs, the Air Staff, and other higher headquarters may direct new equipment requirements and purchases. Replacement equipment can be identified through the use of the 3-Year Equipment Budget Requirements List or by the user. Regardless of how equipment is

identified, or by whom, it is your job to ensure that MEMO is involved from day one.

2. The approval authority for most equipment items rests with the MTF Commander. The Commander is authorized to approve requests for EXPENSE (Operation and Maintenance, or O&M, funds) medical equipment costing less than $100,000. INVESTMENT equipment over $100,000 (Other Procurement, or OP, funds) must be approved at higher headquarters. The vast majority of the equipment your MTF will purchase is expense equipment and will be approved locally. The approval authority will determine the extent of justification required and the process for approving equipment. Some MTFs require all equipment requests to meet an Equipment Review Authorization Activity (ERAA) board, while other MTFs merely want the equipment packages routed through the executive committee for pre-approval prior to the commander signing the request.

3. Most equipment requests will come to MEMO from the RC/CC Equipment Custodian on AF Form 601. This form and other supporting documents like a 13-Point Justification and company literature become the basis for MEMO's screening, coordination, and approval process. The justification and AF Form 601 should answer several questions:

a. What equipment is required?

b. What is the cost?

c. What are the potential sources of supply?

d. Is this a replacement item?

e. How is the function this equipment will perform being performed now?

f. Who will install the equipment?

g. Who will repair the equipment and train users on its operation?

h. How much will it cost to operate the equipment?

i. What consumable supplies are required?

j. Will any hazardous materiel be required or will any hazardous waste be generated? If so, are there alternatives that would use less hazardous materiel or generate less hazardous waste?

More information on equipment justification and approval can be found in AFMAN 23-110, Vol 5, Chap 18.

4. Ensure you fully coordinate on all equipment requests, PRIOR to the requests meeting the approval authority. Complete coordination through the BMETs, Facility Management (Civil Engineering if required), and other "players" will help make your job much easier when the new equipment arrives.

5. In a perfect world, money would be available to purchase all equipment as soon as it is approved. The reality is that money will not always be available, so approved/unfunded equipment must be prioritized. The prioritization of approved/unfunded equipment is a potentially caustic process. The approval authority is responsible for actual prioritization. MEMO may be charged with presenting a proposed prioritized list based on specific criteria from the approval authority. In any case, Logistics must

maintain the list and advise the approval authority on changing requirements and situations that impact the priority of items.

6. **M**edical equipment can be rented or leased for use in MTFs when it is determined to be more advantageous or cost effective to the government. When making the decision whether to rent or buy, ask some of the following questions:

a. How often will the item be used?

b. Will the requesting physician be reassigned soon or will changing technology render the item obsolete in a short period?

c. Is this item for one patient only?

d. What are the terms of the rental, i.e., daily rental, monthly, yearly?

e. Is there a requirement to purchase supplies with the rental?

A new tool, the Tactical Resource Development Tool (or TRDL), will provide automated justification menu, comparison option and lease/purchase analysis

7. **O**nce approved and funded, you can purchase the equipment. If Base Contracting will purchase the item for you, they will require a detailed item and source specification. Make sure you include the "essential item characteristics" that finely identify what the equipment is, what you require it to do, and where it may be acquired. If there is only one acceptable model or source, additional justification may be necessary. The user of the equipment and the BMETs can help MEMO with this critical process. Numerous other sources exist for acquiring equipment, such as the VA Buyer Program, General Service Administration (GSA), and government credit card (for items under $2500). Make sure there is no doubt about what you want, or you might get a big surprise when the new item arrives.

8. **W**hen the new equipment arrives, the BMETs should thoroughly inspect and test it. New equipment should be installed and delivered to the requesting provider as soon as possible after it is received. Nothing aggravates a physician more than knowing their new item has arrived, and not being able to use it.

9. **M**EMO is also responsible for controlling the internal transfer and turn-ins of equipment for the MTF. If one section has a piece of equipment no longer needed, but can be used by another section, MEMO will transfer the item to the new account and have the gaining custodian sign for the item. MEMO will also work closely with your materiel branch coordinating reports of excess equipment to other AF MTFs and turning in unserviceable equipment to DRMO.

10. **E**quipment control and accountability is the final area we will cover regarding MEMO. It should not be taken lightly! Each custodian is responsible for the equipment under their control (shown on their Custody Receipt/Locator List). MEMO is the focal point for any potential misuse, theft, or loss of accountable equipment. MEMO is also the focal point and responsible for conducting an annual equipment inventory of all the equipment items in the MTF. Equipment custodians should assist MEMO with the inventory. Missing equipment may require a Report of Survey. See Vol 5, Chapter 12, Attachment 2 and Vol 5, Chapter 18, paragraph 18-26 and Attachment 9 for details.

The paragraphs above were merely the tip of the iceberg of the MEMO program. You should strive to understand how requirements are identified, know the different approval levels/authorities, and learn the acquisition process. In other words, read Chapter 18 in AFMAN 23-110, Vol 5. If you're not familiar with varied aspects of the program, you won't be able to answer those never ending questions. Stay attuned to the status of the equipment due-ins. Don't make the medical staff ask you what's happening with their equipment. Let them know the status of their equipment and what you are doing to speed the process.

I. VEHICLE CONTROL:

Logistics is normally responsible for the MTF vehicle management program. AFI 41-209 covers the specifics.

J. MANAGING OUTSOURCING:

Management of outsourced, or contracted, services is becoming more important throughout the Government. At any given facility, we may outsource housekeeping, grounds maintenance, equipment repair, or professional services such as physicians, nurses or laboratory personnel or other services. Medical Logistics' role in the process begins in the earliest stages, when the requirement is in the definition process, continues with coordination with the contracting office in the procurement process, and on into administration of the contract to completion or termination.

During requirements definition, medical logistics will coordinate with the users of a particular service to determine what exact services are required, working hours, number of hours or providers required, and so forth. Medical Logistics will then generate a purchase request, or PR package, which will describe the requirement to contracting. One critical part of the PR package is the performance work statement, or PWS. This will have most of the information described above regarding type of services, work hours and so forth. Medical Logistics writes the PWS from input supplied by the user, with the coordination and assistance of contracting. Many PWSs are already available in template form from HQ AFMSA/SGSLC. These only require tailoring of specific paragraphs of the PWS to the individual MTF situation, and a review by HQ AFMSA/SGSLC when complete. Other PWSs, for an all new service, will require composition from scratch, and can take two to (gasp!) six months to complete. So start early.

QUALITY ASSURANCE EVALUATORS (QAEs)

When a service is contracted out, the Government must be certain we are getting the service we are paying for. The QAE is the person responsible for verifying this. Other designations for this position are contracting officer's technical representative, or contracting officer's representative (COTR or COR). Whatever the title, the incumbent of this position has an important role. AFI 63-504 details the qualifications and procedure for nominating a QAE. There must be at least one primary and one alternate QAE for each service contract. For small contracts, the QAE will work multiple contracts. If a contract is large enough, the QAE will work it full-time. For very large contracts, such as the TRICARE contracts, there are multiple QAEs (called COTRs in TRICARE) and a QAE reporting chain that goes through several layers of authority.

The QAE must have sufficient technical knowledge and experience in the area being contracted to enable them to observe contractor performance and determine whether the service does or does not meet the contract standards. For example, the QAE for a contract for emergency room physicians will be a Government physician, either military or civil service; the QAE for an equipment repair contract might be a Government equipment repair technician, and so forth.

The final QAE duty we will touch here is in PWS development. Whether an all-new PWS, tailoring an SGSLC template, or updating the PWS from the existing contract, the QAE should be involved in the PWS development process. This necessitates QAE selection and appointment as early in the acquisition process as possible, so the QAE can participate from the beginning. The Functional Area Chief (FAC, described below) will nominate the QAE to the MTF commander for appointment, and after appointment notify the contracting officer of the selection and request QAE training be set up by the contracting office.

QAE manning is always a sore subject. QAE slots are frequently not available, or are not funded, and as a result QAEs work part-time on numerous contracts. Persistence in asking for QAEs and slots can pay off. Getting your RMO to update the UMD for new contracts, counting the newly required QAEs, will help. AFI 63-504 gives suggested QAE manning.

THE FUNCTIONAL AREA CHIEF

The Functional Area Chief (FAC) is the individual responsible for a functional area, which is the organization having responsibility for the actual performance of a given service, whether it is done in-house or by contract. The FAC in an MTF setting is normally the Director of Medical Logistics, delegated FAC duties for contracted services by the squadron commander. Depending on the situation at a specific facility, however, FAC duties may be delegated to another individual at the MTF with more direct responsibility for contracted services.

The FAC is responsible for generating the purchase requirements package for contracted services, and also has numerous responsibilities relating to quality assurance evaluators (QAEs). The FAC is also responsible, with the servicing personnel office, for determining minimum qualifications for QAEs for a given function. The FAC will nominate to the commander, or appoint (if authorized by local procedures) qualified individuals to positions as QAEs. The FAC ensures the QAEs maintain proficiency in their functional areas, and evaluates their job performance at least annually. The FAC will also, if requested by the contracting officer, coordinate in the review of the quality assurance surveillance plan(QASP). A checklist is used to verify compliance with the QASP and establish an audit trail, and the QAE forwards the completed checklist to the FAC to be retained in the FAC's contract file to show objective evidence of performance prior to approving invoices for payment.

K.TRAINING OPPORTUNITY:

Several opportunities exist for expanding your knowledge of Medical Logistics.

1. Medical Logistics Symposium. Five day seminar held each fall. Functional experts from numerous areas instruct Medical Logistics OICs and Superintendents on issues affecting the field. POC: HQ AFMSA/SGSL DSN: 240-3946.

2. Medical Logistics Workshops. Yearly three day class held in various geographic locations. Primarily held to train junior/mid level Medical Logistics enlisted personnel on technical aspects of the position. POC: HQ/AFMSA/SGSL DSN: 240-3949.

3. Small Purchase Acquisition Course:

PUR 102, Operational Level Simplified Acquisition Fundamentals. Periodic 2 week class offered primarily at Lackland AFB TX. Provides training on broad range of base level simplified acquisition responsibilities. Required for limited warrant consideration. POC: HQ AFPC/DPKZ, 555 E. Street West, Ste 1, Randolph AFB TX 78150, DSN 487-6551. For more information, visit Web site http://www.acq.osd.mil/dau

4. Joint Medical Facility Management Course (Basic) (J3AZR4A271-012): 21 day class offered 4-5 times yearly at Sheppard AFB TX. Provides initial training for new facility management personnel. POC: HQ AFMLO/FOM-F, DSN 343-4081.

5. Facility Management Symposium. Yearly 5 day seminar held in conjunction with American Society of Healthcare Engineers annual meeting. POC: HQ AFMLO/FOM-F, DSN 343-4081.

L. CAREER OPPORTUNITIES:

Logistics is the most exciting area an MSC can work in. Of course, this publication, written by career "loggies," is completely objective on this point. There are three basic types of individuals who work in Logistics: those who love logistics and want to stay in it their entire career, those who are counting the days until they can get back into anything else, and those who aren't too sure if this is where they want to settle but enjoy it for the time being. This section is directed at those of you in the first and third groups.

1. **L**ogistics holds tremendous opportunities for those who want to pursue them. Often the question is "How do I get out of here and start moving up my career path." Too often people new, not only to the logistics field, but to the Air Force, think that career progression consists of small hospital, large facility, Medical Center, MAJCOM, and the Air Staff. If this happened we'd have no one above the rank of Captain in a facility, everyone would be in a staff position. Careers should consist of objectives to be strived for, but not strict timetables for accomplishment. The argument about generalist vs. specialist will rage as long as both groups exist. Certainly a generalist background is very useful in some circumstances where an overall perspective on a particular issue is needed, but when you need detailed information on depot operations, AFWCF management, or high cost equipment acquisitions, a "specialist" is where you turn. More important than which "camp" you fall into, is being very good at whichever approach you follow. Too often new officers develop the attitude, "It isn't what you know, but who you know." The more realistic approach should be, "It's not only what you know, but who you know, and how you've impressed those who know you." Reputation is something you cannot buy, is difficult to earn, and easily lost. In a career field as small as the Medical Service Corps in general, and Logistics specifically, it is critical. Jobs are filled with the best person available at the time based on past performance. What this means to you is two fold, do a good job in the job you are in now, and let your career monitor know your desires.

2. **O**ne of the toughest things you have to overcome is getting your desires known. Certainly you should be talking to your MAJCOM about this. In the large commands, jobs are often filled with known assets. Like any company, the MAJCOMs like to hold on to their "hot properties." One of the best ways to get yourself known to the Logistics community is to volunteer to speak at the annual Medical Logistics Symposium. Sure, it's a risk presenting in front of all those people, especially senior logisticians, but it also puts your face and name in front of those who can shape your career. Often the new logistics officer feels they don't know enough about anything to speak. Don't forget, almost a third of the attendees are in their first account as well and many have not been in an account for several years. If there is a program you've been involved in that has worked

out particularly well, or not so well, if you've done some reading on some aspect of logistics that is developing in the civilian community that may impact us, if your base has been through some unique experience such as a hurricane and you had to support relief efforts, etc., they would all make interesting presentations.

3. For others, an Air Force Institute of Technology (AFIT) assignment is an option. AFIT at Wright-Patterson offers a graduate degree in Logistics Management. It is a 16 month program which gives an overall perspective on the entire Logistics field. The program is not geared to medical logistics and your classmates come from a diverse "line" background. There is usually only one slot per year available for this program, although as many as three MSCs have attended when there were qualified applicants. The ideal candidate is a junior captain who has at least one account under his/her belt. Many people would rather attend a civilian AFIT program rather than a "military" school. While attendance at Wright-Patterson is different than attending a civilian institution, like wearing a uniform to class, and adhering to AFI 36-2903 dress and appearance standards, it does offer some unique opportunities. The program is specifically designed around the military system. Everything presented is applicable to the system you have come from. The program is one of the few logistics masters degree programs available. The person who applies for AFIT Logistics program is certainly branding themselves as a "loggie," although many go on to broader careers later.

4. There are also a number of good fellowships available every year to qualified individuals. These have included working at ECRI, a 4 month long internship at the Defense Personnel Support Center (DPSC) in Philadelphia, and a fellowship at HQ AFMSA. All these offer excellent opportunities in a career broadening program. These programs are targeted for captains who have had enough experience to make the internship experience worthwhile.

5. Talk to your career monitor. HQ AFMSA/SGSL (DSN 240-3948) carefully monitors the staff requirements for medical logistics jobs. While they do not make the actual assignment, they strongly influence these decisions. The MSC Utilization Specialist at MPC is just as interested in placing the right person in the right job as your career monitor is, which is why MPC listens carefully to the recommendations from HQ AFMSA/SGSL. It is important to review the MPC "Medic" BBS for current job openings. Discuss the pros and cons of each job with your mentor, your MAJCOM Medical Logistics Officer, the HQ AFMSA/SGSLP Medical Logistics Consultant to MPC, and your Administrator. When you are ready to volunteer, contact the MPC folks by E-mail or phone to let them know your desires.

6. What do you do if you get an assignment to a place you don't want to go, to a job you have no interest in, at a time when it is very disruptive to your personal life? Unfortunately, there are assignments to bases and jobs that are tough to fill. Your resource monitor and MPC try their best to fill all jobs with volunteers, but there comes a time when this is not possible. Sometimes taking on one of these less than desirable jobs earn you high marks as a "company man/woman." Someone who is willing to take the tough job for the good of the organization. Often you can swing a very good assignment as a follow on. Surprisingly, many people find that the "worst" assignment possible

turns out very well. The challenges are great and the rewards very visible.

7. If you are a new officer or just getting into logistics, now is the time to start building your reputation. Work hard at learning all you can at your first assignment. Suggest further learning, i.e., AFMLO orientations, workshops, calls to peers at other accounts, MAJCOM, AFMLO, AFMSA, all to teach and help. They are your resources -- take advantage of them. If you are in a small facility, you will have a chance to see all aspects of the medical logistics account. Take it all in, try new things, change approaches to old problems, take a few chances, and have fun!

APPENDIX 1

USING THE BASE MEDICAL INVENTORY MANAGEMENT REPORT

1. This report is produced monthly during End of Month processing. A report image file is also forwarded to AFMLO/FOS when produced. This report provides a management tool for controlling Medical-Dental Division (AFWCF) assets and is used at base level, MAJCOM, and HQ USAF. The report has a lot of useful information for you, the manager, it:

a. Reflects the total dollar value, number of records, and percent of the total operating balance records for operating serviceable on-hand.

b. Computes average pipeline time for the operating balance records.

c. Shows the percentage of unique coded records with a level (those records for which you control the stock control level).

d. Shows total dollar value and number of records of economic retention on-hand for the operating balance records. There technically is not a separate balance field for economic retention, as it is included with the operating balance. It does tell you what would be there if it were a separate inventory category.

e. Shows total value and number of records of excess on-hand and lists the dollar value of excess reported.

f. Shows issue fill rate. This is computed as a percentage of line items requested for issue divided into the number of line items issued for records with a stock control level. Partials count as a complete fill.

2. Review of this report is important in order to allow you to manage your account on a day-to-day basis. Following the value of operating to the dollar value of economic retention, will indicate the quality of inventory management practices. Although you won't see stock actually in economic retention (it is carried in operating), you will see the dollar value as it would be. You may have to rethink how you are setting initial levels, identifying excess. Keep in mind that economic retention is all potential excess, as it is stock which exceeds the levels.

a. You should use the average pipeline time to make management decisions concerning default pipeline time. You need to know average pipeline times to intelligently assign priorities to requisitions, declare shipments lost, etc.

b. The percent of unique coded levels is another management indicator. Excessive use of unique level codes may mean you're over controlling your stock levels. Whenever possible, let the computer maintain your levels.

c. Excess on record and excess reported will give you an indication of whether your personnel are actively identifying and reporting your excess. Rule of thumb should be: "If it's in excess, it should be reported." It also gives you another indication of the management practices you use. Don't let your people hide discrepancies or shortages in excess. This will show up as unreported excess because naturally they would not report something they don't have. These figures should normally appear as an upside down pyramid, with the larger dollars in requirements code 0, etc. That's because excess should be generated due to non-usage, thus the requisition coded items will steadily decrease. You want to be sure you're not generating excess through improper ordering practices.

APPENDIX 2

LETTERS OF AUTHORIZATION/APPOINTMENT

	DOCUMENT	AUTHORITY	APPOINTED BY
1)	Base Medical Supply Officer	AFMAN 23-110, Vol 5 Chap 1, para 1.4	Installation commander
2)	Certificate of FM Account Transfer	AFMAN 23-110, Vol 5 Chap 1, para 1.6.4	N/A
3)	Base MEMO Officer	AFMAN 23-110, Vol 5 Chap 18, para 18.3.5	MTF Commander
4)	Certificate of MEMO Transfer	AFMAN 23-110, Vol 5 Chap 18, para 18.24	N/A
5)	Medical WRM Project Officer	AFMAN 23-110, Vol 5 Chap 15, para 15.3.3	MTF Commander
6)	Representative for Approval of LP	AFMAN 23-110, Vol 5 Chap 16, para 16.2.2	MTF Commander
7)	Request for Controlled Area Designation	AFI 31-209	Base SPS
8)	Storage for Medical Logistics Vault Combination	AFMAN 23-110, Vol 5 Chap 23, para 23.4.2	MTF Commander
9)	Controlled Medical Item Custodian	AFMAN 23-110, Vol 5 Chap 14, para 14.1.3	Accountable Officer/ Log Flight Commander
10)	Controlled Area Monitor	AFI 31-209	MTF Commander
11)	Controlled Area Access List	AFI 31-209	MTF Commander
12)	Destruction Officers (Code Q & R)	AFMAN 23-110, Vol 5 Chap 12, para 12.2.2	MTF Commander
13)	Authorization to Sign for Registered		MTF Commander

14)	Appointment of Nutritional Medicine Services Officer	AFI 44-135	MTF Commander
15)	Appointment of VCO/VCNCO		MTF Commander
16)	Appointment of Linen Supply Officer	AFMAN 23-110, Vol 5 Chap 21, para 21.2.1	MTF Commander
17)	Appointment of LMR Net Managers		MTF Commander
18)	Appointment of PMRP Monitors	AFMAN 23-110, Vol 5 Chapter 14, para 5.2	MTF Commander
19)	Appointment of TASO Coordinator		Med Log Flight Commander
20)	Appointment of Base Service Store and Tool Issue Account Custodian(s)		MTF Commander
21)	Power of Attorney for DEA Order Forms	AFMAN 23-110, Vol 5 Chap 16, para 16.19.2	Med Log Flight Commander
22)	Authorized Personnel to Approve Individual Equipment Requests	AFMAN 23-110, Vol 5 Chap 10, para 10.25	MTF Commander
23)	Self Inspection Monitors		Med Log Flight Commander
24)	Determination of Need for Appropriate Markings on MTF Linen	AFMAN 23-110, Vol 5 Chap 21, para 21.6	MTF Commander
25)	Method of Marking Clothing Items	AFMAN 23-110, Vol 5 Chap 21, para 21.6	Med Log Flight Commander
26)	Personnel Authorized to Pick Up Data Products		MTF Commander
27)	Appointment of Reports of Survey Monitors		MTF Commander
28)	Pallet/Net Monitors		MTF Commander

29)	Appointment of Mobility Equipment Custodians	MTF OPLAN	MTF Commander
30)	Appointment of Air Cargo Couriers	MTF OPLAN	MTF Commander
31)	Appointment of Classified Materiel Couriers		MTF Commander
32)	Appointment of Mobility Officer and NCO	MTF OPLAN	MTF Commander
33)	Entry to Mobility Concept Briefing	AFI 10-403	MTF Commander
34)	Authorization to Sign UMPR		MTF Commander
35)	Designation of Critical Care Areas	AFI 41-201	MTF Commander
36)	Appointment of PV Ordering Officers		Med Log Flight Commander
37)	Appointment of Functional Area Chief		Squadron Commander
38)	Appointment of Quality Assurance Evaluators (QAE), Contracting Office Technical Representatives (COTR), or Contracting Officer Representative (COR)	AFI 63-504	MTF Commander

APPENDIX 3

IMPORTANT FINANCE PRODUCTS

SMAS

AF Stock Fund Approved Operating Program (SH118-SG0) **Sec 9.3.2 Fig 9-1**
Reflects approved operating program provided by the Division Manager (AFMLO).

AF Stock Fund Approved Operating Program Status (SH118-SF0) **Sec 9.3.3 F9-2**
Reflects actual position of the account compared to the approved position.

Billed Not Received Follow-up Letters **Sec 7.3.29 Fig 7-3/7-4**

Daily Processing Summary, Section II, Pts 1 & 2 (SH118-FM0) **Sec 11.3.12 Fig 11-6**
Pt 1 "Interfaces Processed Today" provides list of interfaces since the last end of session.
Pt 2 "Interface Sequence Control" lists all interfaces processed during the previous 45 days.

Daily Transaction History (SH118-SO0) **Sec 11.3.2 Fig 11-4**
Lists all transactions that update the general ledger.

Interfund Accounts Payable Open Item List (SH118-VJ0) **Sec 7.3.28 Fig 7-8**
Contains all interfund detail records which have actions pending.

Medical Materiel Management Report (HAF-SGS(M)7136) **Sec 9.3.7, Fig 9-5**
Used to evaluate the financial position of the entire inventory.

MEDLOG Due-In vs SMAS Interfund Detail Reconciliation List (SH118-VN0) **Sec 7.3.31 Fig 7-10**
Identifies differences...corrections should be coordinated with Medical Supply

MILSTRIP Research & Follow-up List, Part I (SH118-VE0) **Sec 7.3.32 Fig 7-5**
Used to determine if invalid details exist on the data base. Medical Supply should annotate any deletions.

Monthly Transaction History, (SH118-SP0) **Sec 12.3.2 Fig 12-8**
Lists all transactions processed in SMAS during the month, including all MEDLOG and IAPS transactions.

Reject Suspense Listing (SH118-TC0) **Sec 11.3.3 Fig 11-2**
Rejected transactions stored awaiting correction.

Trial Balance (SH118-SA0) **Sec 3**
Reflects the balances for each general ledger account.

Unprocessed Interfund Detail Transactions (SH118-VG0) **Sec 7.3.26 Fig 7-6**
Sent to logistics to annotate action that must be taken to clear the rejected detail. Must return within 5 days.

IAPS

Billed not Received Follow-up to Supply (SH086-TQ000022)
Notification of items billed but not received. Logistics must research and respond ASAP.

MEDLOG to IAPS Interface List (SH086-TQ000230)
Lists all MEDLOG transactions that pass through black box processor to IAPS.
Part I - Accepted transactions
Part II - Rejected transactions
Part III - Transactions not processed - information only.
Part IV - MEDLOG Interface Summary...provides an overview of the entire interface process.

Outgoing IAPS Interface List, Parts II & III (SH086-TQ000037)
Part II - Displays medical transactions except payments sent to SMAS.
Part III - Displays medical payments created during the end of day process.

Outstanding Stock Fund Rejects List (SH086-TQ000233)
Displays all stock fund rejected transactions awaiting correction.

FUNDS CONTROL MODULE (FCM)

Funds Exceeded List (PCN SH118-PAO)
Lists the status of all records with total obligations exceeding the fund control target and records flagged by the user for inclusion even though there is no fund control target.

Funds Summary List (PCN SH118-PGO)
Lists all customer and acquisition fund accounts matching select criteria in the reports request record. The report is generally produced on request for distribution to requesting activities such as the base Financial Analysis office, stock fund Funds Manager and resource advisors.

Funds Status List (PCN SH118-PBO)
Lists the status of customer and acquisition funds as specified by the user in the Funds Management Matrix Records. Used to monitor financial status of accounts.

FCS Reject Suspense List (PCN SH118-PPO)
Lists all records stored in the system's reject suspense file. Reject suspense records will continue to print each day until corrected or deleted from the database.

FCM Transaction History List (PCN SH118-PCO)
Lists selected processed transactions. Negative reports will be generated when no records are found matching select criteria in the FRR record.